The Order of St. Augustine of the Mercy of Jesus

St Clare's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 20 and 21 February 2018, the first day of the inspection was unannounced.

At the last inspection in June 2015 the home was rated Good.

St Clare's Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

St Clare's Care Home provides nursing or personal care for up to 60 adults over 65 years of age, some of who are living with dementia. At the time of our inspection there were 59 people living at the home. Accommodation is provided in a purpose built, two story building set in large grounds in a rural area of East Sussex.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe, staff knew how to recognise and report abuse. However, staff told us at times they were using unplanned restraint. We found when allegations against staff had been made, the Care Quality Commission and local authority had not always been notified.

Where risks to people were identified, some of the risk assessments lacked information and guidance for staff to follow to reduce the risks.

Medicines were stored and administered safely, where people required staff to support them to apply topical creams, consistent application records were not always kept.

People's rights were not fully protected because consent to care and treatment was not always sought in line with current legislation.

People's care records were not consistently accurate. There was a system in place for people and their relatives to be involved in reviewing the care people received.

The systems and processes in place to monitor and drive improvement were not fully effective at identifying shortfalls in the service.

There were enough staff available to meet people's needs, the service was using agency staff to cover vacant shifts and they endeavoured to use the same staff where possible to aid consistency. The provider followed

safe recruitment procedures.

People were protected from the risk of infection and the provider ensured people lived in a safe environment because regular checks on the environment were carried out.

Staff felt they received enough training to meet people's needs, they commented positively about the training and support they received.

People received adequate nutrition and hydration and they commented positively about the dining experience. Consistent records were not always kept where people had their fluid intake monitored.

People were supported to see health professionals when required and staff acted upon their guidance.

The provider had plans in place to improve the environment to meet the needs of people who were living with dementia.

People and their relatives spoke positively about the staff supporting them. Our observation of staff interactions were positive. Staff described how they supported people in a way that promoted their privacy and dignity. Staff spoke positively about the people they supported.

There were a range of activities on offer for people to take part in. Our observation of people's engagement in activities was mixed.

People, their relatives and staff had the opportunity to provide feedback on the service and where feedback was given, the provider had acted upon it.

People and their relatives knew who the registered manager was, and they felt able to approach them with any concerns. People, their relatives and the staff spoke positively about the registered manager.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Where risk to people were identified, some information was lacking from the risk assessments.

People's medicines were stored and administered safely, some of the medicine administration records were not consistently completed.

People were supported by staff who knew how to recognise and report abuse.

Staff had used unplanned restraint when supporting people on occasions.

They were enough staff available to meet people's needs.

People were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not fully effective.

People's rights were not fully protected because the correct procedures were not always followed where people lacked the capacity to make decisions for themselves.

People were supported by staff who were positive about their training and support.

People received adequate nutrition and hydration and were mostly positive about the meals provided.

People received appropriate healthcare support.

The provider had plans to improve the environment to further meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the staff supporting them.

People's privacy and dignity were respected.

There were ways for people and their representatives to express their views about the care they received.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People's care records were not always consistently and accurately completed.

People had access to a range of activities, our observations of people's experience of meaningful engagement was mixed.

People and their relatives knew how to raise concerns and were confident they would be resolved.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The systems in place to monitor the service were not fully effective.

Notifications of significant incidents were not always submitted to the Care Quality Commission in line with legal requirements.

People , their relatives and staff commented positively about the registered manager.

There were systems in place to receive feedback from people, their relatives and staff.

St Clare's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 and 21 February 2018 and this first day was unannounced.

The inspection was carried out by two adult social care inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialism of the expert by experience was caring for a person living with dementia.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel the service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with five people who lived at the home, nine visitors and 16 members of staff. Staff spoken with included registered nurses, care staff, activity coordinators, the chef and ancillary staff. The registered manager, training manager and care manager were also spoken with during the inspection.

Some people were unable to fully express themselves verbally due to their physical or mental frailty. We therefore spent time observing care practices throughout the home and carried out a Short Observational Framework for Inspection (SOFI) in one area. SOFI is a way of observing care to help us to understand the experience of people who could not talk to us.

We looked at a selection of records which related to individual care and the running of the home. These included nine care and support plans, charts identifying how and when people had received support with eating, drinking and repositioning, five staff files, medication administration records, minutes of meetings,

audits and records of complaints. Following the inspection we requested feedback from three professionals.

Requires Improvement

Is the service safe?

Our findings

People, who were able to told us they felt safe at St Clare's Care Home. One person told us, "I feel safe here." Relatives also thought people were safe, comments included, "We feel [name of person] is very safe here" and "My Mum is much safer here than at home." We saw people looked relaxed in the presence of staff.

Staff said they completed training on how to protect people from avoidable harm and abuse. Comments included, "I've done my training. I know how to report concerns. We have to report concerns; we've been taught that we are people's advocates."

Some people in the home became anxious when they were supported by staff with personal care. We saw evidence of staff following the correct process for the majority of these incidents. However, two staff members told us staff had used unplanned restraint for one person when they became anxious during personal care. One person's care plan stated they had the mental capacity to make decisions about their daily living. Records demonstrated at times the person was refusing staff assistance for their personal care, and at times they were becoming anxious about this. When we discussed this with staff we received conflicting information about how they supported the person at these times. One staff member told us staff had to physically hold the person during personal care, because the person was hitting out. Another staff member said that they had heard that sometimes staff covered the person's hands with a blanket to prevent them (staff) from being hit. This meant at times staff had physically held the person against their wishes.

All the other staff we spoke with told us they followed the guidance in place by leaving the person and another staff member would try and offer support. Whilst there was guidance in place for staff instructing them of the action to take if the person became anxious during personal care, there was no guidance in place for staff that stated restraint could be used for the person. The registered manager told us they were not aware that staff were using any form of unplanned restraint. The registered manager also told us they would inform all staff they should not be using any form of restraint and they would ensure clear guidelines were put in place.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records that showed one member of staff had reported concerns about an agency worker. Although the concerns had been raised with the agency provider which meant the worker had not returned to the home, this had not been raised with the local safeguarding team and a notification had not been made to the Care Quality Commission (CQC). We were told of another instance where a person had raised concerns about staff, and whilst this had been reported to the local safeguarding team, the incident was not reported to CQC. It is important that providers notify CQC about safeguarding incidents so that we can ensure the correct action is taken. The registered manager told us they would ensure retrospective notifications were completed. Where concerns had been raised in relation to staff conduct we saw action was taken towards the staff member in line with the provider's policy.

When risks had been identified, care plans provided some guidance for staff on how to reduce the risks. For example, care plans contained risk assessments for areas such as falls, skin integrity and malnutrition. However, we found in some cases the information in the assessments was limited and did not always provide enough guidance for staff. For example, where people had been assessed as being at risk of developing pressure sores, the plans did not always include details about any pressure relieving aids that were in use or whether people needed to have their position changed regularly. Despite this, position change charts showed that people did have their positions changed frequently and air mattresses were set correctly. Some people had been assessed as being at risk of falling. We saw that sensor mats were being used to alert staff when people moved however these were not always referred to within the care plans. This meant that staff might not always have access to information on how to keep people safe.

People had personal emergency evacuations plans (PEEPs) in place. The PEEPs included information about the persons mobility and how many staff would be required to evacuate them in the event of an emergency. We looked at one person's PEEP who may be reluctant to accept staff assistance during an emergency evacuation. The person's plan stated they were 'non-compliant'. Although staff were aware of the action they would take, the PEEP did provide information for staff on how they should support the person in the event of them needing to be evacuated in an emergency.

Lack of detailed information in the risk assessments was of particular relevance because of the home's reliance on agency staff. We discussed this with the registered manager who told us they would ensure the risk assessments would include this detail.

Other plans did provide clear guidance for staff. When staff needed to use equipment to move people safely, the plans detailed the hoist and sling details. Some people's mobility varied from day to day and in these instances the plans detailed how staff should assess people prior to supporting them.

When incidents occurred these were recorded. The registered manager told us they reviewed incidents with the care manager to identify any themes and trends to prevent further incidents. They told us how they looked at where lessons could be learned and improvements made to people's care. Records demonstrated where people had been involved in accidents these were reviewed and analysed, and any preventative measures or action required, for example, referrals to relevant health professionals were recorded.

There were enough staff on duty to meet people's needs. The service was currently reliant on agency staff due to staff vacancies, but the majority of staff said they felt there was enough on duty. One said "We're using lots of agency; we need more care staff." Another said "We use agency a lot, but there's enough of us." Staff confirmed the same agency staff were usually booked to provide consistency. During the inspection staff were visible and call bells were answered swiftly. There was a tool used by the registered manager to assess the numbers of staff that were required. The registered manager told us they had recently introduced an additional staff member [team leader] on each shift and the records we viewed confirmed this.

The provider had procedures in place to ensure that only suitable staff were recruited. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Medicines were managed safely. The service was using an electronic medication administration recording system. One staff member administering medicines said "It's much safer. It prompts us, alerts us if

medicines are overdue and prevents errors." We saw that when staff administered medicines they didn't rush people, and checked they had a drink. They asked if they needed additional medicines such as pain relief.

Some people had been prescribed additional medicines on an as required basis. Protocols were in place to inform staff when and why these might be required by people and these were personalised.

Some people were having their medicines administered covertly. This is when medicines are disguised in food or drink. Although capacity assessments had been completed and best interest decisions made in line with legislation, the guidance for staff was not always clear. In one person's plan it had been documented that they could only tolerate medication in liquid form and that they took their medicines in milk. However, there was nothing documented to inform staff if it was safe to mix all liquid medicines into one glass of milk or whether staff needed to administered each medicine separately. We discussed this with the nurse on duty during our inspection who said they would discuss this with the pharmacist.

Medicines were stored safely including those which require additional storage. Regular stock checks were carried out. The temperature of medicine storage areas was monitored.

Some people were prescribed medicines, such as creams or lotions. There were clear instructions for staff on when and where to apply these. However, their administration records had not always been signed by staff to indicate that they had been applied. For example, one person had been prescribed a liquid to wash with. The instructions were documented as "Use 1 capful in bath or shower daily." The administration charts for this person had not been signed by staff daily. There were 10 gaps during January 2018 and one during February 2018. Another person had been prescribed a spray to be used during incontinence care, but staff had not signed the chart on nine days during February 2018. This meant there was a risk that people did not always have creams and lotions applied as prescribed.

There were systems in place to ensure people were protected from the risk of the spread of infection. The provider employed a team of housekeeping staff to maintain a clean home. Staff had access to and wore personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system and water temperature checks.

Requires Improvement

Is the service effective?

Our findings

Peoples rights were not fully protected because consent to care was not always sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

MCA training had been provided to staff, but staff did not always demonstrate a good understanding of the legislation. Records demonstrated when people had capacity to consent to aspects of their care; there were no consent forms in place to confirm this. Additionally, not all staff understood that if a person had capacity to consent, that a best interest decision was not required. This was also evidenced by the capacity assessments that had been completed by staff. Where capacity assessments were in place, these were not decision specific, but instead covered a range of decisions, such as nourishment, mobility, bed rails, safety and personal care.

Because the assessments were not decision specific it was not clear how people had been assessed for their capacity to consent to all aspects of their care or if they lacked capacity to make specific decisions. In particular those aspects that constituted a form of restraint, such as bed rails, sensor mats and tilt chairs. When these were in use, there was also nothing documented to show that staff had considered other less restrictive ways of keeping people safe.

Despite this, we did observe staff asking people's consent prior to supporting them. For example, we heard staff knocking on one person's bedroom door and saying "Hello. Are you ready to get up yet or would you like me to come back later?" One staff member said "I always ask people and I always give them choice."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had an understanding of the Mental Capacity Act and worked in partnership with relevant authorities to make sure people's rights were protected. Some people had authorised DoLS in place and others had been applied for where appropriate.

Staff told us they received an induction when they started working in the home. They told us the induction covered training and a period of shadowing more experience staff, and they thought this was enough to enable them to commence their role. The induction was linked to the Care Certificate. The Care Certificate standards are recognised nationally to help ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff said they had the skills and knowledge to undertake their roles. They said they had access to training and that if needed they were able to request further training. One member of staff said "I'm doing my NVQ

level 2 at the moment, which the company is paying for." Nurses said they had access to professional development in order to meet their professional registration requirements. One said "The training is face to face. We can ask for any extra training we need, such as catheterisation." Staff also confirmed they received an induction when they started working in the home and they spoke positively about the training and support they received during this.

We spoke with the training manager who told us they had arranged for training road shows to be carried out for a week. They told us this enabled staff who may find it difficult to attend training dates, such as night staff, to have the opportunity to drop in to sessions and attend the learning. They told us how the road shows had involved mandatory training subjects last year, and this year they were focusing on themes such as end of life care, safeguarding, equality and diversity and aging health conditions. The training manager told us how the road shows had been a success and they had received positive feedback from staff. Records demonstrated staff attended training in subjects such as; moving and positioning people, infection control and dementia.

Staff had regular supervision meetings with their line manager to discuss their work, personal development and training. We saw records of these meetings, which showed staff were given opportunities to discuss their personal development and any aspects of their work they felt was working well or not so well. Staff spoke positively about the support they received. They said "I feel well supported and I can always speak to one of the nurses if I need to" and "We have regular supervisions and yearly appraisals."

People mainly spoke positively about the meals provided in the home. Comments included, "There's always plenty of choice. I find supper a bit early at 5.30 but they're always happy to keep it for me. They are very accommodating" and "The foods getting better." A relative commented, "My Mums not that fussy with food but she loves being in the dining room with all her friends." One comment was made about one of the meals being, "Too modern." The registered manager was aware of this and taken action to ensure the person did not receive this meal again.

People chose where they wanted to eat. One person told us, "I prefer to eat in my own room." We heard one member of staff say to one person "Do you fancy coming down for breakfast? They've got some lovely sausages, I've just had some." When the person replied they would rather stay in their room, the staff member replied "Of course, that's fine. I'll bring your breakfast up to you." We observed the lunchtime meal being served in the dining room and there were two options available, one of these being a vegetarian option. Meals were served promptly and people were not left waiting for their meal.

People were supported to have enough to eat and drink. People's weight was monitored. When people lost weight, support and advice was sought in a timely manner. Records showed that when people were reviewed by the speech and language therapist (SALT) for example, that the advice and recommendations were incorporated into the care plan. We spoke to the chef who had a record of people's preferences and dietary requirements in the kitchen. When people had been assessed as being at risk of choking the plan detailed the position the person should be in when eating or drinking and how staff should support them; such as the use of a teaspoon rather than a dessert spoon. We observed staff supporting people in line with this guidance during our inspection. People's food and drink preferences had been documented.

Some people were having their fluid intake monitored. Although recommended targets were documented in the care plans this information was not written onto the fluid charts. This meant it would not be easy for staff to know whether people were meeting their targets or not. Although staff had written the total fluid intake for each 24 hour period on the chart, there was nothing documented to show that staff had identified

poor fluid intakes or that they had escalated their concerns. For example, we looked at the fluid charts for one person. It had been documented in the care plan that the daily target for this person was 1.2 litres per day. However, the fluid charts showed that on 16 February 2018 the person had 480 mls and on 19 February 2018 they had 435 mls. On other days the target was met, but this was not consistently seen. Staff said the person had "good days and bad days", but this information was not written within the care plan.

Additionally, staff had not always documented when they had offered people a drink and people refused. Other fluid charts we looked at showed that people generally drank at least one litre of fluid per day, but as before, no targets were written on the charts. We discussed this with nurses, team leaders and the registered manager during the inspection. The registered manager said the current fluid chart design was being reviewed.

People had access to on-going healthcare. One person told us, "A doctor visits every Wednesday." Relatives commented, "They were very responsive when [name of person] had an infection" and "They have rung me when [name of person] has had a fall, they always contact us. They're happy to get the GP out. They're very good like that."

The GP visited the service three times a week. Records showed that when staff assessed people as needing to be seen by the doctor that the reason was documented. Additionally the outcome of the GP review was documented and staff signed to confirm they had read this. People were also referred to and seen by Speech and Language Therapist (SALT), the tissue viability nurse, the local hospice and the mental health team for example. One staff member said "It's easy for us to communicate with other teams to ask for advice or support. I faxed the SALT only the other day and they came and saw the resident the following day."

The registered manager, care manager and provider had plans in place to improve the environment to make it more 'dementia friendly'. This included introducing signage and creating a dementia friendly garden that could safely and be accessed by people independently. There were communal spaces in the home, including lounges and seating areas, which enabled people to choose where they spent their time. One of the lounges was themed around the 1940's. People also had access to a cinema room, a prayer room and a large communal dining room with a seating area at the side.

Good

Is the service caring?

Our findings

People and their relatives spoke highly of the staff team and their experience of living at St Clare's Care Home. One person told us, "I have no complaints about the regular staff at all." Comments from relatives included, " We're very positive about St Clare's it's been a great experience" and "They are very good here, I can't fault them."

We saw many examples of positive interactions between staff and people using the service. We observed staff throughout the building greeting people by name and showing an interest in how they were. For example, "Good morning [person's name]. How are you today?"

We saw that when staff were taking people to the lounge or the dining room, they had a conversation with them as they took them to their destination. For example, we saw one staff member pushing someone in a wheelchair to the lounge. They were talking about the weather and said "Doesn't it look nice out there with the sun shining at last?" and "Can I get you anything?" On another occasion a member of staff gave someone a cup of tea and said "Here you go. I know it looks lovely out there, but it's still cold."

One member of staff was finishing their shift and went into the lounge. They went up to every person in the lounge and said goodbye to them all by name and said they would see them all the following day. On another occasion we saw a staff member helping someone get ready to go to the dining room. They looked at the person and said "Oh hang on, you've got some lipstick on your teeth. Let me get a tissue for you."

Care plans included information about people's likes, dislikes, preferences, what is important to them and personal histories and most of the staff we spoke with were able to tell us about this information. One staff member told us how they had discussed a photograph that one person had in their room and how this had prompted a conversation about the person's previous life experiences. Another staff member told us they knew the information was in one person's room but they couldn't remember without looking at this.

People's privacy and dignity were respected. We observed staff knocking on people's doors during the inspection. One person told us, "Yes they always knock, I have no problem." Staff described how they ensured people had privacy and how their modesty was protected when providing personal care. For example, closing doors and curtains and explaining what they were doing.

People chose what they wanted to do and how and where to spend their time. Some people chose to stay in their rooms; others chose to spend time in the lounges. Relatives and visitors were able to visit the home when they wished, we saw many visitors visiting during our inspection. The registered manager told us how one person was supported to use technology to contact their relative each week and they used the homes large screen smart TV to do this. A health professional commented that they felt welcome when they visited the home.

The service had implemented "Resident of the week". There was a poster on display with pictures of the person to inform staff and visitors who the person was. The same poster was on the person's bedroom door.

One visitor of the person who was resident of the week during our inspection said "The staff wrote to tell me that mum was resident of the week. It means her room is deep cleaned, we get invited for lunch, she's been out on her own with the activities staff and is generally pampered. It's nice to think she is the centre of attention." We saw there was a plaque on the dining table where the person sat for their meals, stating they were resident of the week. Relatives commented positively about this process where they had been involved .

Staff spoke positively about their roles. They said, "The care here is good. People's choices are respected. I know people get good care because I check", "The staff here put their heart into the job. They're working here because they love their jobs" and "People rarely go into hospital; for me, that means we look after people well." The service had received compliments; an example included, "I want to congratulate the team for the good care and attention they give."

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them. People's physical, mental health and social needs were assessed and these formed the basis of care plans. The home used an electronic care planning system, but also had printed copies of the plans available for staff to access easily. Some of the care plans we reviewed were not accurate and contained conflicting information, the content of the paper plans were not always a duplicate of the electronic plans. For example, we looked at the pressure sore care plan for one person. The wound plan was available electronically, but had not been printed off. Photographs of the wound had been taken, but these were not saved in the electronic plan or the paper care plan. This meant there was a risk that staff might not always have access to the most up to date information about the wound. Having an up to date picture of a pressure sore is important because it enables staff to effectively monitor the healing process.

Additionally, the quality of the documentation was not always of a high standard. For example, we looked at one person's plan. Inside was an assessment with two other people's names on and not the person to whom the plan related to. The form had been printed and signed by a staff member on 11 January 2018 but the error had not been noted. In another [female] person's plan, there was an assessment form with a male person's name written in the outcome section. In one person's bed rails assessment staff had documented the person did not require rails, and then later in the form contradicted this by documenting that rails were in place.

Care plans were person centred in places but this was not seen consistently throughout all of the plans we looked at. For example, the personal hygiene plan for one person guided staff to "Pay attention to colour scheme and comfort" and "Dress in own clothing." There was no detail about what kind of clothes the person preferred to wear, or their preferred colours of choice. Other care plans we looked at contained detailed descriptions of the clothes people chose to wear. People's toiletries preferences had not always been documented, although people's preference for male or female staff was.

Despite the disparity between some people's care records we found people received care that was responsive to their needs. The registered manager had a system in place to ensure people and their relatives were involved in reviewing people's care. Relatives told us, "We discussed a care plan when [name of person] first arrived and are reviewing it today" and "I have looked at [name of relatives] care plan. I have a recent copy."

Plans in relation to people's health needs were in the main detailed. For example, diabetes plans described the signs and symptoms people might display when hypoglycaemic (low blood sugar levels) and the actions staff should take were detailed. Catheter care plans described the signs and symptoms of urinary tract infections and informed staff of the steps to take in order to prevent this occurrence. Where one person had limited verbal communication we saw this was detailed in their care plan, with details of how the person communicated and how staff should respond. The staff we spoke with had a good knowledge of this.

Personal life histories had also been documented. The information from these had been used where

appropriate to provide staff with information on how to meet people's mental health needs. For example, we looked at the plan for one person who sometimes displayed agitation and anxiety. The plan described how the person's past might influence how they responded to staff when upset. Additionally, the guidance for staff on how best to support the person during periods of agitation were detailed.

People's social needs care plans were personalised. For example, people's preferred TV programmes were listed, the type of music they enjoyed, and things they had an interest in. However, our observations of people engaging in meaningful activities and occupation during our inspection were mixed. For example, on the second day of the inspection we observed three people who were living with dementia, sat in their wheelchair or chair with tables in front of them for a period of time with nothing on the tables to occupy them. One person was rocking and talking to themselves and fiddling with their fingers during this time. A fourth person was sat in one of the hallway seats talking and calling out for a period of time. We observed there was a lack of objects, such as sensory items, magazines and soft toys for these people to interact with.

Other people living at the home were actively engaged in the activities and appeared to enjoy them. For example, we observed people enjoying a music therapy session. One relative told us, "The activities staff have transformed my mum. It's the first time in five and a half years that she is happy." Another commented, "[Name of person] has been involved in trips to the garden centre, there seems to enough going on her for them."

There were two activity coordinators employed by the home who offered a range of activities available for people to take part in if they wished to. Activities included; bingo, crosswords, quizzes, films in the cinema room, a cheese and wine afternoon and keep fit. A local choir also visited the home. One person told us, "[Name of activity coordinators] come and see me and the nuns most mornings."

There were also day trips arranged each week for people to go out into the community to garden centres for example. One person told us, "I'm going out next Tuesday." The person who was resident of the week had a day allocated where they could choose to access the community place of their choice. There was a holistic therapy room in the home and one of the Sisters offered holistic therapies for a small charge. For people who preferred to stay in their rooms, records were kept of the one to one time they spend with staff. There were also a range of events organised such as Christmas parties, summer parties and

The care manager told us how the home had purchased a virtual reality headset for people to use and how this had been a great success. The registered manager told us this was being used to promote understanding of the experiences of people living in Dementia. The virtual reality headset involved creating virtual experiences of being in different environments such as the jungle and sea. We saw feedback recorded about the session's people had been involved in and it was recorded if people enjoyed the activity or not. Some of the positive comments we saw included; "[Name of person] said it was magic and she loved it", "Said it was fantastic" and "Delighted, the family were so appreciative and thankful." The care manager showed us a local article where the use of the virtual headsets had featured on local BBC news, stating they were "Showcasing the great work that is being undertaken to provide meaningful activities for people."

People's spiritual and religious beliefs were supported. Care plans documented each person's religion and whether they wished to practice their chosen religion. The home had a prayer room that people could access and a priest regularly visited the home and conducted services for those who were not able to attend the church in the grounds. The registered manager told us people from all faiths and none were welcome at the home and would be supported to practice their faith in a way they wanted to. This meant people's spiritual needs were met in a supportive way.

Systems were in place to enable people to have a comfortable death. The service was part of the National Gold Standards Framework in End of Life Care. This is a framework which enables care settings to provide a 'gold standard' of care for all people nearing the end of their life. Advanced care plans were in place.

These were particularly detailed and described people's wishes for where they wanted to die and whether they wanted to be admitted to hospital in an emergency. People's spiritual preferences, if any, were documented. The service had links with the local hospice to ensure they provided end of life care in line with best practice. One staff member said "We have a good relationship with the hospice. They're just a phone call away of we need any support." Another said "We try to start conversations with people as soon as possible so that we can understand what they want to happen when the time comes."

We spoke with two relatives of a person who had passed away a few days earlier. They spoke highly of the end of life care that had been provided. They said "The staff told us what would happen, so we knew what to expect. The local hospice were involved and the staff here assured us they would seek advice from them if needed." And "The staff here gave Mum maximum peace and support when she needed it most."

People and their relatives felt able to raise concerns and were confident these would be dealt with. Comments from people included, "I feel able to bring up complaints" and "If I had a complaint I would tell [name of registered manager]." Relatives told us, "If I notice a problem I tell them and they put it right. We spoke to them about the positioning of the cushions on a chair; we've had no problem since. We speak to whoever is around at the time" and "If I had a complaint I would go straight to the manager or Louise at reception." There was a complaints process in place and we saw complaints were recorded and investigated in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the service. These included a range of audits completed by the registered manager, deputy manager and care manager. The audits covered areas such as medicines, accidents and incidents and safeguarding referrals. The registered manager also told us they completed a monthly audit which was submitted to the care manager.

We reviewed the medicines and incidents audits and found they were identifying some of the action required to drive quality and improvement. For example, the accident and incident audits identified where referrals were required to external professionals to seek further advice and guidance.

However, the systems in place were not fully effective in identifying all of the shortfalls we found during our inspection. For example, the medicines audit had not identified the cream administration records had not been fully completed by staff and that care plan reviews had not identified some of the care plans were not accurate. In addition, failing to undertake robust monitoring of care provision had not identified that some staff were using restraint during personal care. This meant the systems in place to monitor and improve the quality and safety of the service were not fully effective.

There was a registered manager in post. The registered manager told us they were aware of their responsibility to notify the Care Quality Commission of significant events, however we found on two occasions they had not notified us of allegations of abuse. The registered manager told us they would send in retrospective notifications for these incidents.

The registered manager was also a registered nurse, they told us they were well supported by the provider. They said they attended the provider's regular managers meeting and local authority provider meetings to share ideas keep themselves up to date with any changes and new initiatives.

The registered manager maintained a regular presence in the home and they had a good knowledge of the people and the staff who supported them. They spent time in all areas of the home which enabled them to constantly monitor standards. The registered manager and care manager also conducted unannounced visits during the night to enable them to monitor care over 24 hours.

People and their relatives knew who the registered manager was, they spoke highly of them and told us they would feel comfortable approaching them. One relative told us, "[Name of registered manager] and his team are very approachable. I wouldn't hesitate to communicate with them."

Staff also spoke highly of the registered manager and the deputy manager. Comments included, "I like the manager and the deputy. I can speak to either of them and they both really listen", "[Name of registered manager] is really good, I've got no complaints, he listens" and "The manager is so good. I like him. He's so professional."

There were systems in place for people and their relatives to provide feedback on the service. These

included twice yearly residents meetings. People and relatives were aware of the residents meetings and although the people we spoke with had chosen not to attend the relatives confirmed they had. Records demonstrated feedback was sought on the menus, activities and laundry as well as information being communicated to people around new initiatives such as 'resident of the week'.

There were also systems in place to communicate information to people and their relatives in the form of newsletter. These gave details of up and coming events , people who had passed away, a residents column where a person gave information about their past history and achievements and who was nominated employee of the season.

Staff feedback was also sought and acted upon. We looked at the results of the latest staff survey which showed that 78% of responses received by staff were positive. The details of planned actions following the survey, such as improving communication had been communicated to staff. Staff were also encouraged to make suggestions for improvements throughout the year. We saw that these suggestions had been reviewed by the management team. For example, staff had asked for the main door opening times to be reviewed and this had been actioned. The care manager told us how they had involved staff in redeveloping the supervision process and format.

The registered manager showed us a diagram for the vision of the home which encompassed areas such as person centred care, dignity and respect, nutrition and hydration, safeguarding from abuse and dementia friendly environment. Staff understood the values of the organisation. One member of staff said, "The really good thing about this company is that it really tries its best to care for residents and their families." Other comments included; "We are here to provide good care, make sure residents are safe and their needs are met" and "We are here to give good quality care and meet residents needs and I think we do that."

Staff spoke positively about the culture of the home. One staff member commented, "I've worked a other places, but I prefer it here. We get listened to. They [the management] take our opinions seriously. Staff are treated with respect." Another commented, "The team are friendly and support each other." Employees, managers, residents and visitors to the service were invited to nominate staff for an "Employee of the season" award. The winner of the award was presented with a monetary voucher.

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "They ask us what we would like to improve and we can make suggestions, we discuss everything, I feel listened to." Meeting minutes reviewed demonstrated items discussed included day to day items such as; policies, feedback from people and relatives, team building and use of equipment. Records demonstrated there were also meetings held with all of the departments in the home, such as catering and housekeeping and administration staff. This enabled messages to be communicated throughout the team.

There were strong links with the local community. The provider was well known locally and the registered manager said many retired or ex-employees and relatives continued to visit the service. They said the summer fete was well supported each year as well as other events such as visiting choirs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Some care and treatment was provided in a way that included acts intended to control or restrain. Regulation 13(4)(b)